Virginia

Indigent Health Care Trust Fund

Program Guide

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I. Introduction

The Virginia Indigent Health Care Trust Fund is a public/private partnership involving the state government and the acute care hospitals in the state in an effort to equalize the burden of charity care among the hospitals. The purpose of the fund, created in 1989, is to reimburse hospitals for part of the cost of charity care, which is defined as hospital care for which no payment is received and which is provided to any person whose family income is equal to or less than 100% of the federal poverty level (in 1999 $16,700 annually for a family of four).

Some, but not all, profitable hospitals make contributions to the Trust Fund based on the amount of charity care they provide. Proprietary hospitals receive a credit for the amount of state corporate taxes they actually pay. No hospital pays more than 6.25% of its operating margin to the Fund. Hospital contributions are matched by general fund contributions.

In addition, a disproportionate share level is established which is no more than three percentage points above the median level of charity care. Contributions for charity care provided above this disproportionate share level are made entirely from state general funds.

Payments are made to hospitals based on the charity care the hospital provided in excess of the median amount of charity care for all hospitals, adjusted by each hospital's cost to charge ratio. The Trust Fund will then pay up to 60% of these charity care costs. Total Trust Fund disbursements in state FY 1999 were $10,225,779.

II. Qualifying Charity Care Defined

Charity care means hospital care for which no payment is received and which is provided to any person whose gross annual family income is equivalent to or less than 100 percent of the federal nonfarm poverty level as published for the then current year in the Code of Federal Regulations. Hospital inpatient and outpatient medical services qualifying for reimbursement from the fund are limited to those categories of inpatient and outpatient hospital services covered under the Medical Assistance Program excluding any durational or newborn infant service limitations. Qualifying charity care for the purposes of the Trust Fund log is always a subset of charity care for GAAP purposes. Contractual adjustments do not qualify for the charity care log and only items actually charged to charity care on the hospitals financial records during that fiscal year are eligible for the log during that same year.

Chapter 912 of the 1996 Virginia Acts of Assembly requires the Board of Medical Assistance to implement a fully prospective reimbursement system for inpatient hospital services based on a Diagnosis Related Groups (DRG) methodology. Chapter 782 of the 1996 Virginia Acts of Assembly requires the State/Local Hospitalization (SLH) Program to conform inpatient hospitalization reimbursement to the Medicaid Program's DRG methodology. Therefore both programs will be transitioning over a three year period from a per diem basis of reimbursement.

Under the previous Medicaid hospital reimbursement system effective through June 30, 1996, Medicaid coverage was limited to 21 days for adults. As a result, hospitals could count as charity care claims for adult Medicaid recipients for hospital days in excess of 21 days. Medicaid has implemented a DRG hospital reimbursement system, which no longer limits adult Medicaid coverage to 21 days. During fiscal years 1997 and 1998, the new reimbursement system was partially effective and hospitals could count two-thirds and one-third of the claims for excess days for fiscal years 1997 and 1998 respectively. Effective July 1, 1998, hospitals can no longer count as charity care claims for adult Medicaid recipients for hospital days in excess of 21 days. Note that hospitals are still receiving interim payments based on the old reimbursement formula, but will eventually be cost settled based on the new reimbursement formula.

No change was made to reimbursement for inpatient psychiatric claims. Claims for inpatient hospital days in excess of 21 days can still be counted as charity care. Medicaid inpatient rehabilitation claims have not been subject to the 21 day inpatient hospital stay limitation.

The SLH program has a 21 day inpatient hospital stay limitation. Therefore, hospitals may continue to count as charity care claims for days denied beyond the 21 day SLH limit.

Eventually SLH hospital claims will be based on DRGs. DMAS will notify hospitals when DRG reimbursement will be effective for SLH. When DRGs are effective for SLH, claims for excess days will no longer be able to be counted as charity care.

Covered services consist of inpatient and outpatient hospital services covered under the Medicaid program for which the hospital receives no payment. Contractual adjustments are not qualified charity care.

The Medicaid Program has contracted with Health Maintenance Organizations (HMO) to provide for hospital care for participating Medicaid recipients. That portion of the capitation fee paid to HMOs to cover inpatient hospital services is to be considered payment in full for such services. The difference between usual and customary charges and the rates negotiated with Medicaid HMOs should be recognized as a contractual adjustment, not qualified charity care.

III. Timetable for Data Submission, Calculations, Billing, Collections and Payments

July 1 - November 30:

DMAS collects data needed to calculate contributions and payments. All hospital charity care certifications and audits as well as the financial data are due within 120 days of the end of the hospital's fiscal year.

December 1 - December 31:

DMAS calculates individual hospital contributions and payments.

January 1 - January 31:

DMAS sends hospitals a preliminary spreadsheet for review. If necessary, DMAS sends a revised spreadsheet. DMAS mails bills for contributions from individual hospitals.

February - March:

Hospitals remit Trust Fund contributions to DMAS.

April - June:

DMAS remits Trust Fund payments to hospitals (timeliness dependent upon completion of previous steps).

IV. Procedures for Evaluating Income to Determine Eligibility for the Trust Fund

Individuals whose gross annual family income is equal to or less than 100 percent of the federal non-farm poverty levels as published in the then current year in the Code of Federal Regulations are eligible for charity care. Income must be documented. This may be accomplished by obtaining a statement of income at the time of service signed by the responsible party. Trust Fund eligibility is determined using the poverty level in effect at the time the service is rendered.

The federal poverty guidelines are usually published in February of each year and are effective for Trust Fund purposes March 1.

INCOME LEVELS

The 1997 Poverty Income Guidelines for Virginia are:

Family Size	Annual Income	Monthly Income
1	$7,890	$658
2	$10,610	$884
3	$13,330	$1,111
4	$16,050	$1,338
5	$18,770	$1,564
6	$21,490	$1,790
7	$24,210	$2,017
8	$26,930	$2,244

For family units greater than eight members add $2,720 per year for each additional member.

The 1998 Poverty Guidelines for Virginia are:

Family Size	Annual Income	Monthly Income
1	$8,050	$671
2	$10,850	$904
3	$13,650	$1,138
4	$16,450	$1,371
5	$19,250	$1,604
6	$22,050	$1,838
7	$24,850	$2,071
8	$27,650	$2,304

For family units greater than eight members add $2,800 per year for each additional member.

The 1999 Poverty Income Guidelines for Virginia are:

Family Size	Annual Income	Monthly Income
1	$8,240	$687
2	$11,060	$922
3	$13,880	$1,157
4	$16,700	$1,392
5	$19,520	$1,627
6	$22,340	$1,862
7	$25,160	$2,097
8	$27,980	$2,332

For family units greater than eight members add $2,820 per year for each additional member.

The total gross income of the applicant, and those of his/her legally responsible relatives with whom she/he resides, will be used to determine eligibility. Total gross countable income for this purpose includes all gross earned and unearned income.

A. Standards:

1. Income is defined as total gross wages, Title II benefits, Railroad Retirement benefits, Veteran's benefits, Social Security benefits (SSA) and any other predictable income, either earned or unearned.

2. The number of people dependent on the income is to be established. It will include, in addition to the applicant, the spouse, the parents (if the applicant is a minor who is not emancipated), and other person(s) properly claimed as dependent on the income for subsistence, who is (are) not a recipient of SSI or Auxiliary Grants payment.

3. Support from a spouse or parent (natural, adoptive, or stepparent) living in the home is assumed to be available to the spouse and dependent children under 21 who are also living in the home, except that no part of an SSI or Auxiliary Grant payment or any income of a recipient of either program can be counted in determining eligibility.

4. Eligibility will be determined by using the poverty level scale provided annually in the Code of Federal Regulations.

5. The scale is used by comparing the income of the number of dependent family members to the scale.

B. Income Disregards:

Funds from the following sources received by members of the household will not be regarded as income in determining eligibility:

1. Home produce utilized for the household's consumption.

2. The value of food coupons under the Food Stamp Program.

3. The value of foods donated under the USDA Commodity Distribution Program.

4. Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.

5. Any benefits received under Title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965, as amended.

6. Any grant or loan to any undergraduate student for education purposes made or insured under any program administered by the US Commissioner of Education. Programs that are administered by the US Commissioner of Education include: Pell Grant, Supplemental Education Opportunity Grant, Perkins Loan, Guaranteed Student Loan (including the Virginia Education Loan), PLUS Loan, Congressional Teacher Scholarship Program, College Scholarship Assistance Program, and the Virginia Transfer Grant Program.

7. Any funds derived from the College Work Study Program.

8. A scholarship loan, or grant obtained and used under conditions which preclude its use for current living costs.

9. Training allowances (transportation, books, required training expenses and motivational allowances) provided by the Department of Rehabilitative Services (DRS) for persons participating in vocational rehabilitation programs. The disregard is not applicable to the allowance provided by DRS to the family of the participating individual.

10. Any portion of the SSI payment and/or Auxiliary Grant.

11. Payments to VISTA Volunteers under Title I, when the monetary value of such payments is less than the minimum wage as determined by the Director of the Action office, and payments for services of reimbursement for out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) and other programs pursuant to Titles II and III, Public Law 93-113, The Domestic Volunteer Service Act of 1973. The worker must contact the Action Office at the following address or telephone number when VISTA payments are reported: Corporation for National and Community Service, 400 North 8th Street, Richmond, Virginia 23219, telephone 804-771-2197.

12. The Veterans Administration education amount for a caretaker who is 18 or older is to be disregarded when it is used specifically for educational purposes. Any additional money included in the benefit amount for dependents is to be counted as income to the assistance unit.

13. Foster care payments received by anyone in the assistance unit.

14. Any unearned income received from the Job Corps by an eligible child is to be disregarded. However, any payment received by any other Job Corps participant or any payment made on behalf of the participant's eligible children is to be counted as income to the assistance unit.

l5. Income tax refunds exclusive of the earned income tax refund (EIC).

16. Any payment made under the Fuel Assistance Program.

17. The value of supplemental food assistance received under the Child Nutrition Act of 1966. This includes all school meals programs, the Women, Infants, and Children (WIC) Program, and the child care food program.

18. HUD Section 8 and Section 23 payments.

19. Any unearned income received by an eligible child under Title II, Parts A and B, of the Job Training Partnership Act (JTPA).

20. Any funds distributed to, or held in trust for, members of any Indian tribe under Public Law 92-354, 93-134, 94-540, 98-123 or 98-124. Additionally, interest and investment income accrued on such funds while held in trust, and purchases made with such interest and investment income.

21. Tax exempt portions of payments made under the Alaska Native Claims Settlement Act (Public Law 92-203).

22. Income derived from certain submarginal land of the United States which is held in trust for certain Indian tribes (Public Law 94-114).

23. Disaster assistance payment made through the Individual and Family Grant Program (IFG).

C. Computation:

1. Earned Income

Determine monthly gross income by averaging actual gross income received or expected to be received in the month of application and the preceding two months. Compute average as follows: Convert weekly, biweekly, etc., gross income to a monthly amount using Aid to Dependent Children (ADC) methodology, for each of the three months in question, total, and divide by three. This figure will represent the gross monthly income figure to be used in computation. Income from a terminated source will not be considered in computation. An example would be a person who had been employed until their hospitalization, and who will not be able to return to work. Unless that person has another continuing source of income, he/she would be considered to have no income for computation purposes. These steps would be followed for each member of the household who has income. Net income for all members will be added together before applying a final figure to the poverty scale. Add any unearned income to the net earned income total. The result is net countable income.

The net countable income is compared to the poverty scale for the appropriate household size.

2. Unearned Income

Other case income received by the household is considered to be unearned income. This includes, but is not limited to, Social Security benefits, Veterans benefits, Railroad Retirement, alimony payments, child support payments and cash contributions. Unearned income will be added in total to the net earned income figure to determine net countable income.

V. Hospital Charity Care Record keeping Requirements

Hospitals are required to maintain certain information on each patient provided "charity care" as defined by the Virginia Indigent Health Care Trust Fund. The patient specific data that hospitals shall maintain are limited to the following:

- Gross Family Income
- Family Size

- Admission Date/Discharge Date
- Principal Diagnosis
- Total Charges Related to the Stay

Hospitals are required to report annual charity care totals within 120 days after a hospital's fiscal year end. Hospitals must certify that the services for which care was provided are covered services under the Trust Fund statute (see Certification Statement Appendix A).

At the end of the fiscal year, the hospital's audit firm will test a valid sample from the hospital's data file. The auditors will analyze the sample to determine:

a) The data collected for each charity patient is complete.

b) The amount of gross family income is appropriate as defined by the accepted definition.

c) The amount of total charges coincides with the hospital's accounts receivable records.

d) The total charges all apply to the fiscal year reported.

The auditor does not have to validate the services.

Each hospital's audit firm will issue a special report to DMAS no later than 120 days after the hospital's fiscal year end.

The independent audit firm will submit an agreed upon procedures report to the hospital which will indicate that the steps enumerated below have been performed:

1. Obtain charity care log from hospital.

2. Foot net charges submitted for reimbursement on the log and indicate the total charity care for which reimbursement is being requested.

3. Perform an attribute sample on the charity care log with the objective of obtaining a 95 percent confidence level that the error rate for each attribute is less than 10 percent. The sample should be selected and audited as follows:

a. Select a random sample of 100 line items.

b. For each line item, perform the following tests:

1. Determine that the gross family income per the log is equal to or less than 100 percent of the Federal non-farm poverty level as published annually in the Code of Federal Regulations.

2. Determine that the total charge per visit agreed with the accounts receivable subsidiary ledger.

3. Determine that the net charges submitted for reimbursement agree with the amount written off of the accounts receivable subsidiary ledger.

4. Evaluate the sample as follows:

a. If there was one or fewer errors for each of the above steps, the sample should be accepted as you have achieved the desired confidence levels.

b. If there were two errors in any of the above tests, the sample must be extended only for each test that had two errors. An additional sample of thirty items must be selected and each attribute having two errors in step 1 must be tested for each of the thirty new sample items. If there are no additional errors detected, you may stop. The sample has achieved the desired confidence level.

c. If three to six errors were noted for each attribute, either in the original sample of 100 or the sequential sample of 130, the sample must be increased so that a total of 180 randomly selected items is tested. If there are six or fewer errors for each attribute, the sample can be accepted, and the desired confidence level has been achieved.

d. If errors exceed six for any attribute, the confidence level has not been achieved. At that point the log must be returned to the hospital to be corrected.

e. The sampling procedures must be repeated after the log has been corrected.

VI. Submission of Charity Care Data

The hospital will be required to *routinely* submit *only* the audit firm's annual special report described in the previous section and the hospital's Certification Statement (see Certification Statement Appendix A). The certification statement and audit report is to be submitted to DMAS no later than 120 days after the hospital's fiscal year ends. It is not necessary to send the charity care logs. DMAS may grant one 30-day extension of the filing date to hospitals unable to meet the 120 day requirement. Auditors with questions regarding the submission of the annual special report may contact the Indigent Care Program Manager at telephone number (804) 371-6326. The audit firm's annual special report should be sent to:

Virginia Indigent Health Care Trust Fund Program
Fiscal Unit Division of Cost Settlement and Audit
Department of Medical Assistance Services
Suite 1300
600 East Broad Street
Richmond, Virginia 23219

VII. Extensions

Emergency extensions of the data submission requirements will be considered on a case-by-case basis. Extensions must be requested in writing 30 days prior to the required date for submission. Hospitals not reporting within a reasonable time frame will be brought to the attention of the Technical Advisory Panel (TAP).

VIII. Submitting Data in Hardship Cases

Procedure for Alternative Data Gathering in Cases of Extreme Hardship - The TAP agreed by consensus that hospitals considering themselves in "extreme hardship" would petition the TAP to be allowed to use an alternative data gathering method. "Extreme hardship" means hospitals which are unable to meet the data collection and reporting requirements of the Trust Fund legislation because of a natural disaster or other circumstances beyond their control. Hospitals found to be in this condition would be allowed to substitute cost reports submitted to the Board of Health for the previous year rather than that of the most recent year's financial data.

IX. Non-residents of Virginia

Hospitals providing charity care to patients living outside Virginia will be able to include those cases in their total amount of charity care.

X. Enforcement and Compliance

The TAP recognized that for proper Trust Fund operations to take place, 100 percent hospital participation is required. In addition to the Class I misdemeanor, as applicable by statute, the TAP agreed that should a hospital decide not to participate, that DMAS use the most recent year's data to calculate distribution amounts. Further, the TAP agreed that Trust Fund payments to recipient hospitals will be reduced proportionately by the non-participating hospital's amount. Also, there will be no retrospective adjustment of a hospital's data or history of charity care should a non-participating hospital decide to submit its data.

XI. Submission of Financial Data

DMAS obtains hospital financial data for Trust Fund calculations from the Board of Health, which has contracted with Virginia Health Information (VHI) to collect financial data. DMAS uses “total gross patient service revenue,” “net patient service revenue,” “state income tax,” “bad debt expense” and “operating income (loss)” from the annual hospital filing to VHI. Total gross patient service revenue is exclusive of long-term care units, but other items include long-term care units. The Trust Fund uses net patient service revenue minus bad debt expense in its calculation. Hospitals are required to submit financial data to VHI within 120 days of the end of the hospital’s fiscal year.

XII. Other Issues

<u>Deductibles/Co-payments</u>

Deductibles and co-payments are the patient's responsibility. Unpaid patient pay balances may be charged to charity care. If a hospital partially collects on a charity care account, the remaining charges, net of payment, would apply as charity care. However, contractual adjustments cannot be charged to charity care.

Calculation of Hospital Cost-to-Charge Ratio

The calculation to be used in determining the cost-to-charge ratio is the total hospital costs divided by total hospital charges as determined by Medicare cost finding principles. This is calculated by DMAS from the Medicare cost report. The numerator is from Worksheet B, Part 1, Column 0, line 103. The denominator is from Worksheet G-2, Part 1, column 3, line 25.

Corporate Taxes

Hospitals paying state corporate taxes will have their charity care cost calculated as: total cost of charity care plus state corporate taxes divided by net patient revenues, as defined by the Board of Health.

Fiscal Year

Trust Fund calculations are based on information for the hospital's fiscal year ending during the state fiscal year. The state fiscal year is from July 1 to the following June 30.

XIII. Frequently Asked Questions Regarding the Trust Fund

1. Will individuals eligible for Medicaid and the State/Local Hospitalization Program automatically meet the income criteria included in the definition of charity care for purposes of the Trust Fund? For example, will individuals who become eligible for Medicaid as a result of a spend down automatically meet the income definition?

   In most instances people who are eligible for Medicaid or the SLH program will meet the income criteria included in the definition for charity care in §32.1-332. However, there are three categories of individuals who may be eligible for Medicaid even though their income exceeds the poverty level. These three categories are individuals who become eligible through a spend down process, qualified disabled and working individuals, and as of April 1, 1990, pregnant women and children under the age of 6 who are members of families with incomes at or below 133 percent of the poverty level. In addition, Fairfax County uses an SLH income eligibility level of 167 percent of the poverty level. All other localities use 100 percent of poverty for determining eligibility for the SLH

Program. (Arlington County and Alexandria and Manassas cities at one time used higher levels but no longer.) None of these individuals automatically meet the income eligibility criteria for reimbursement from the Trust Fund because they may have incomes greater than 100 percent of the poverty level. Therefore, hospitals cannot assume that all individuals eligible for either Medicaid or SLH meet the eligibility criteria for the Trust Fund unless they verify income for those who could have income higher than 100 percent of the federal poverty level.

2. Should hospital charity care logs report the admitting diagnosis or the principal diagnosis?

   At the beginning of the program, hospitals were asked to indicate the admitting diagnosis. The data element requested for the log should have been the principal diagnosis rather than the admitting diagnosis. All future entries should report the principal diagnosis, but it is not necessary to change those entries that have already been made.

3. How are auditors to handle incomplete logs (e.g., information to be provided by the patient such as family size and gross income)?

   Incomplete log entries are to be regarded as errors and handled in accordance with the procedures described in Section V.4.

4. To what extent will auditors be allowed to interpret information on the log?

   The only instance in which auditors should have to interpret information on the log is when the log includes a notation that the patient is eligible for Medicaid or SLH and is not included in any of the categories mentioned in the reply to question number 1. In those instances auditors may interpret the patient's eligibility for Medicaid or SLH to mean that they meet the income and family size requirements.

5. How will the auditors validating the log certify that the services designated as charity care are services qualifying for reimbursement? Will they be required to examine charts and make the determination themselves?

The audit will be accompanied by the Certification Statement signed by the hospital's CEO certifying that to the best of his knowledge the services provided to the individuals listed in the log are limited to services qualifying for reimbursement from the Trust Fund. The auditors shall accept the Certification Statement as validation that the services claimed are limited to those qualifying for reimbursement.

6. Will there be someone within state government to whom hospitals can address questions regarding the Trust Fund?

   Questions regarding the Trust Fund should be addressed to the Department of Medical Assistance Services, Indigent Care Program Manager. If the questions have not been previously resolved, they will be referred to a resolution committee of the Technical Advisory Panel (TAP), the policy making body of the Trust Fund, that will address them as quickly as possible. The Indigent Care Program Manager is located in the Division of Program Operations, telephone number (804) 371-8852.

7. Are charges related to out-of-state patients receiving care in a Virginia hospital eligible for reimbursement from the Trust Fund?

   Charges for services provided to out-of-state patients for care provided in a Virginia hospital are eligible for reimbursement from the Trust Fund if the hospital meets the definition of a hospital included in §32.1-332, if the care provided meets the definition of charity care provided in §32.1-332, and if the services provided meet the requirement for reimbursable services included in §32.1-333 (C)(2).

8. Are nursing home care (ICF and SNF) charges for hospital based nursing care services eligible for reimbursement from the Trust Fund?

   No, they are not. Reimbursement is available only to hospitals licensed to operate as acute care hospitals in the state.

9. Medicare deductible and coinsurance amounts are the patient's responsibility. Can unpaid Medicare deductible and coinsurance charges be applied to charity care?

Yes, they can be treated in the manner described in Section XII. Hospitals may, however, report unpaid Medicare deductible and coinsurance charges to its Medicare cost report for reimbursement. If reported to its Medicare cost report, hospitals cannot count unpaid Medicare deductibles and coinsurance amounts as charity care. Contractual adjustments for Medicare (and Medicaid) cannot be charged to charity care.

Appendix

Certification Statement

Certification of Covered Services
for the Virginia Indigent Health Care Trust Fund

In accordance with the requirements of the Virginia Indigent Health Care Trust Fund, I _____, certify that to the best of my knowledge the hospital services provided as charity care to the patients listed in the log were limited to those categories of inpatient and outpatient hospital services covered under Virginia's Medical Assistance Program in effect at the time the service was provided. These services may exclude durational or newborn service limitations as provided for in §32.1-333., C. 2.

_____ _____

Signature Date

SAMPLE

	Patient Name	Principal Diagnosis	Admitting Date	Discharge Date	Total Charges	Net Charges Claimed for Charity Care	Date Written Off	Family Size	Gross Family Income
1.	Doe, John	Viral Infection	11/22/97	11/25/97	$3,721.00	$2,400.00	1/16/99	1	$612 @ mo.
2.	Sample, Robert	Chest Pain	1/11/98	1/19/98	$13,579.00	$11,400.00	1/19/99	4	$14,275
3.	Example, Sarah	Acute Bronchitis	4/15/99	4/20/99	$4,587.00	$4,587.00	7/1/99	3	$12,400
					A	**B**			**C**

NOTES:

A. Original provider charges.

B. Charges written off during the fiscal year reported. It is possible that a claim can be written off in more than one step and in more than one fiscal year so long as no double counting occurs. Please note that contractual adjustments, including contractual adjustments for Medicaid and State/Local Hospitalization Program claims, are not included in qualifying charity care. Trust Fund charity care does not include all GAAP defined charity care. Only that charity care which reflects the fund's household income guidelines (not to exceed 100% of poverty) can be included in the Trust Fund Charity Care Log.

C. Gross family income and family size are established for eligibility determination at the discharge date and are compared to the federal poverty guidelines in effect at the discharge date. The federal poverty guidelines usually are published in February of each calendar year and are effective for Trust Fund purposes March 1. In the example above the appropriate federal poverty guideline for line "1." is the 1997 level, line "2." is the 1997 level, and line "3." is the 1999 level.

Chapter 11.
Virginia Indigent Health Care Trust Fund.
Sec.
32.1-332. Definitions.
32.1-333. Creation of fund; administration.
32.1-334. Fund contributions.
32.1-335. Technical Advisory Panel.
32.1-336. Annual charity care data submission.
32.1-337. Hospital contributions; calculations.
32.1-338. Distribution of fund moneys.
32.1-339. Frequency of calculations, contributions and distributions.
32.1-340. Annual report.
32.1-341. Failure to comply; fraudulently obtaining participation or reimbursement; criminal penalty.
32.1-342. Rights and responsibilities under this chapter.

§ 32.1-332. Definitions.

Statute text

As used in this chapter unless the context requires a different meaning:

"Board" means the Board of Medical Assistance Services.

"Charity care" means hospital care for which no payment is received and which is provided to any person whose gross annual family income is equal to or less than 100 percent of the federal nonfarm poverty level as published for the then current year in the Code of Federal Regulations.

"The Fund" means the Virginia Indigent Health Care Trust Fund created by this chapter.

"Hospital" means any acute care hospital which is required to be licensed as a hospital pursuant to Chapter 5 (§ 32.1-123 et seq.) of this title.

"Panel" means the Technical Advisory Panel appointed pursuant to the provisions of this chapter.

"Pilot health care project" means any arrangement for purchasing or providing health care, including, but not limited to, any accident and sickness insurance, health services plan, or health care plan.

"Voluntary contributions or donations" means any money voluntarily contributed or donated to the fund by hospitals or other private or public sources, including local governments, for the purpose of subsidizing pilot health care projects for the uninsured.

History

(1989, cc. 635, 747; 1994, c. 466; 1995, c. 333.)

Annotations

The 1994 amendment added the definitions of "Pilot health care project" and "Voluntary contributions or donations."

The 1995 amendment, in the definition of "Voluntary contributions or donations", inserted "or public" following "private" and inserted "including local governments" following "sources".

§ 32.1-333. Creation of fund; administration.

Statute text

A. There is hereby created the Virginia Indigent Health Care Trust Fund whose purpose is to receive moneys appropriated by the Commonwealth and contributions from certain hospitals and others for the purpose of distributing these moneys to certain hospitals subject to restrictions as provided in this chapter.

B. The fund shall be the responsibility of the Board and Department of Medical Assistance Services and shall be maintained and administered separately from any other program or fund of the Board and Department. However, all funds voluntarily contributed or donated to the fund for the purpose of subsidizing pilot health care projects for the uninsured, including any funds voluntarily contributed by local governments, shall be administered by the Technical Advisory Panel in accordance with Board regulations.

C. The Board may promulgate rules and regulations pursuant to the Administrative Process Act (§ 9-6.14:1 et seq.) for the administration of the fund consistent with this chapter, including but not limited to:

1. Uniform eligibility criteria to define those medically indigent persons whose care shall qualify a hospital for reimbursement from the fund. Such criteria shall define medically indigent persons as only those individuals whose gross family income is equal to or less than 100 percent of the federal nonfarm poverty level as published for the then current year in the Code of Federal Regulations.

2. Hospital inpatient and outpatient medical services qualifying for reimbursement from the fund. Such medical services shall be limited to those categories of inpatient and outpatient hospital services covered under the Medical Assistance Program, but shall exclude any durational or newborn infant service limitations.

3. A mechanism to ensure that hospitals are compensated from the fund only for charity care as defined in this chapter.

4. Terms, conditions, and reporting requirements for hospitals participating in the fund.

5. Terms, conditions, and reporting requirements for pilot health care projects for the uninsured.

History

(1989, cc. 635, 747; 1994, c. 466; 1995, c. 333.)

Annotations

The 1994 amendment, in subsection B, in the first sentence, combined the former first and second sentences into the present first sentence, deleted "However, the Fund" following "Department of Medical Assistance Services," and added the present second sentence; and added subdivision C 5.

The 1995 amendment inserted "including any funds voluntarily contributed by local governments" in the second sentence of subsection B.

§ 32.1-334. Fund contributions.

Statute text

The fund shall be comprised of such moneys as may be appropriated by the General Assembly for the purposes of the fund and by contributions from hospitals made in accordance with the provisions of this chapter. The fund may also receive voluntary contributions from hospitals and other entities, including local governments, as specified by law.

History

(1989, cc. 635, 747; 1994, c. 466; 1995, c. 333.)

Annotations

The 1994 amendment, in the second sentence, inserted "voluntary" preceding "contributions" and inserted "hospitals and" preceding "other entities."

The 1995 amendment inserted "including local governments" near the end of the section.

§ 32.1-335. Technical Advisory Panel.

Statute text

The Board shall annually appoint a Technical Advisory Panel whose duties shall include recommending to the Board (i) policy and procedures for administration of the fund, (ii) methodology relating to creation of charity care standards, eligibility and service verification, and (iii) contribution rates and distribution of payments. The Panel shall also advise the Board on any matters relating to the governance or administration of the fund as may from time to time be appropriate and on the establishment of pilot health care projects for the uninsured. In addition to these duties, the Panel shall, in accordance with Board regulations, establish pilot health care projects for the uninsured and shall administer any money voluntarily contributed or donated to the fund by private or public sources, including local governments, for the purpose of subsidizing pilot health care projects for the uninsured.

The Panel shall consist of fifteen members as follows: the Chairman of the Board, the Director of the Department of Medical Assistance Services, the Commissioner of Health, the Commissioner of the Bureau of Insurance or his designee, the chairman of the Virginia Health Care Foundation or his designee, two additional members of the Board, one of whom shall be the representative of the hospital industry, and two chief executive officers of hospitals as nominated by the Virginia Hospital Association.

In addition, there shall be three representatives of private enterprise, who shall be executives serving in business or industry organizations. Nominations for these appointments may be submitted to the Board by associations representing constituents of the business and industry community in Virginia including, but not limited to, the Virginia Manufacturers Association, the Virginia Chamber of Commerce, the Virginia Retail Merchants Association, and the Virginia

Small Business Advisory Board. There shall be two representatives from the insurance industry who shall be executives serving in insurance companies or industry organizations. Nominations for these appointments may be submitted to the Board by associations representing constituents of the insurance industry in Virginia including, but not limited to, Blue Cross/Blue Shield of Virginia, Health Insurance Association of America and the Virginia Association of Health Maintenance Organizations. There shall be one physician member. Nominations for this appointment may be submitted to the Board by associations representing medical professionals, including, but not limited to, the Medical Society of Virginia and the Old Dominion Medical Society.

History

(1989, cc. 635, 747; 1990, cc. 394, 440; 1993, c. 194; 1994, c. 466; 1995, c. 333; 1996, c. 902.)

Annotations

Editor's note. - Acts 1990, c. 394, cl. 2 and c. 440, cl. 2 provide: "That the Technical Advisory Panel shall study the technical and operational considerations related to requiring employers, who do not provide minimum health insurance benefits, as defined by the Commissioner of Insurance, to their employees or whose employees are not otherwise provided such benefits, to make reasonable contributions to the Fund, beginning on July 1, 1992. The Panel shall submit a report on this study to the Board of Medical Assistance Services, The Commission on Health Care for all Virginians [now Joint Commission on Health Care], and the House Committees on Appropriations and Finance and the Senate Committee on Finance, by November 1, 1990. The report shall include alternative plans for requiring such contributions and shall address assessment rates, exemptions, and other administrative, collection, and operational specifics. The Commissioner of Insurance and the Commissioner of the Virginia Employment Commission shall provide the necessary assistance to the Panel in the development of this report."

The 1993 amendment, effective March 15, 1993, added "and on the establishment of alternative health insurance programs for the uninsured" in the second sentence of the first paragraph; in the second paragraph, substituted "fifteen" for "ten," and inserted "the Commissioner of the Bureau of Insurance or his designee, the chairman of the Virginia Health Care Foundation or his designee"; and added the third through sixth sentences in the last paragraph.

The 1994 amendment, in the first paragraph, in the second sentence, substituted "pilot health care projects" for "alternative health insurance programs"; and added the third sentence.

The 1995 amendment, in the first paragraph, in the third sentence, inserted "or public" following "private" and inserted "including local governments" following "sources".

The 1996 amendment substituted "the Commissioner of Health" for "the Executive Director of the Virginia Health Services Cost Review Council" near the middle of the second paragraph.

§ 32.1-336. Annual charity care data submission.

Statute text

No later than 120 days following the end of each of its fiscal years, each hospital shall file with the Department a statement of charity care and such other data as may be required by the Department. The Department may grant one 30-day extension of the filing date to hospitals unable to meet the 120-day requirement. Data required for carrying out the purposes of this chapter may be supplied to the Department by the Board of Health. The Board shall prescribe a procedure for alternative data gathering in cases of extreme hardship or impossibility of compliance by a hospital.

History

(1989, cc. 635, 747; 1990, cc. 859, 873; 1996, c. 902.)

Annotations

The 1996 amendment substituted "Board of Health" for "Virginia Health Services Cost Review Council" in the third sentence.

§ 32.1-337. Hospital contributions; calculations.

Statute text

Hospitals shall make contributions to the fund in accordance with the following:

A. A charity care standard shall be established annually as follows: For each hospital, a percentage shall be calculated of which the numerator shall be the charity care charges and the denominator shall be the gross patient revenues as reported by that hospital. This percentage shall be the charity care percent. The median of the percentages of all such hospitals shall be the standard.

B. Based upon the general fund appropriation to the fund and the contribution, a disproportionate share level shall be established as a percentage above the standard not to exceed three percent above the standard.

C. The cost of charity care shall be each hospital's charity care charges multiplied by each hospital's cost-to-charge ratio as determined in accordance with the Medicare cost finding principles. For those hospitals whose mean Medicare patient days are greater than two standard deviations below the Medicare statewide mean, the hospital's individual cost-to-charge ratio shall be used.

D. An annual contribution shall be established which shall be equal to the total sum required to support charity care costs of hospitals between the standard and the disproportionate share level. This sum shall be equally funded by hospital contributions and general fund appropriations.

E. A charity care and corporate tax credit shall be calculated, the numerator of which shall be each hospital's cost of charity care plus state corporate taxes and the denominator of which shall be each hospital's net patient revenues as defined by the Board of Medical Assistance Services.

F. An annual hospital contribution rate shall be calculated, the numerator of which shall be the sum of one-half the contribution plus the sum of the product of the contributing hospitals' credits

multiplied by the contributing hospitals' positive operating margins and the denominator of which shall be the sum of the positive operating margins for the contributing hospitals. The annual hospital contribution rate shall not exceed 6.25 percent of a hospital's positive operating margin.

G. For each hospital, the contribution dollar amount shall be calculated as the difference between the rate and the credit multiplied by each hospital's operating margin. In addition to the required contribution, hospitals may make voluntary contributions or donations to the fund for the purpose of subsidizing pilot health care projects for the uninsured.

H. The fund shall be established on the books of the Comptroller so as to segregate the amounts appropriated and contributed thereto and the amounts earned or accumulated therein and any amounts voluntarily contributed or donated for the purpose of subsidizing pilot health care projects for the uninsured. No portion of the fund shall be used for a purpose other than that described in this chapter. Any money remaining in the fund at the end of a biennium shall not revert to the general fund but shall remain in the fund to be used only for the purpose described in this chapter, including any money voluntarily contributed or donated for the purpose of subsidizing pilot health care projects for the uninsured, whether from private or public sources.

History

(1989, cc. 635, 747; 1990, cc. 859, 873; 1994, c. 466; 1995, c. 333; 1996, c. 902.)

Annotations

The 1994 amendment, in subsection G, added the second sentence; in subsection H, in the first sentence, added the language beginning "and any amounts voluntarily"; and in the third sentence, added the language beginning "including any money voluntarily."

The 1995 amendment inserted "whether from private or public sources" at the end of subdivision H.

The 1996 amendment substituted "Board of Medical Assistance Services" for "Virginia Health Services Cost Review Council" in subsection E.

§ 32.1-338. Distribution of fund moneys.

Statute text

A. The fund shall compensate a hospital for such hospital's charity care percent less the charity care standard as follows:

1. The payment to each hospital shall be determined as the standard subtracted from each hospital's charity care percent, multiplied by each hospital's gross patient revenues, multiplied by each hospital's cost-to-charge ratio and multiplied by a percentage not to exceed sixty percent.

2. That portion of a hospital's charity care percent which is below the disproportionate share shall be paid from the total amount of the contribution.

3. That portion of a hospital's charity care percent which is above the disproportionate share shall be paid solely from general fund moneys as provided by the General Assembly in the appropriations act.

B. Each hospital eligible to receive a fund payment may elect to return such payment or a portion thereof to the fund to be used at the discretion of the Board, upon the recommendation of the Technical Advisory Panel, for the purpose of establishing pilot health care projects for the uninsured.

C. Money voluntarily contributed or donated to the fund by private or public sources, including local governing bodies, for the purpose of subsidizing pilot health care projects for the uninsured shall not be included in the calculations set forth in this section.

History

(1989, cc. 635, 747; 1990, cc. 859, 873; 1993, c. 194; 1994, c. 466; 1995, c. 333.)

Annotations

The 1993 amendment, effective March 15, 1993, added the subsection A designation, and added subsection B.

The 1994 amendment, in subsection B, substituted "pilot health care projects" for "alternative health insurance systems"; and added subsection C.

The 1995 amendment, in subsection C, inserted "or public" following "private" and inserted "including local governing bodies" following "sources".

§ 32.1-339. Frequency of calculations, contributions and distributions.

Statute text

Contributions to the Fund by hospitals shall be made once annually in January of each calendar year beginning in January 1991, using financial data for the hospitals' most recent fiscal years ending on or before June 30 of the preceding calendar year. Calculations for distributions shall be made under the same terms. The policy and details relating to receipt of contributions and distribution of the Fund moneys shall be prescribed by the Board.

History

(1989, cc. 635, 747; 1990, cc. 859, 873.)

§ 32.1-340. Annual report.

Statute text

The Board and Director shall report to the Governor and the General Assembly prior to the 1990 Session of the General Assembly on any statutory modifications identified by the Board which are required to carry out the purposes of this chapter effectively. In January of 1991, the Board and the Director shall report to the Governor and the General Assembly on all moneys received and distributed and shall make any recommendations for changes with respect to the Fund and its administration.

History
(1989, cc. 635, 747.)

§ 32.1-341. Failure to comply; fraudulently obtaining participation or reimbursement; criminal penalty.

Statute text

A. Any person who engages in the following activities, on behalf of himself or another, shall be guilty of a Class 1 misdemeanor in addition to any other penalties provided by law:

1. Knowingly and willfully making or causing to be made any false statement or misrepresentation of a material fact in order to participate in or receive reimbursement from the Fund;

2. Knowingly and willfully failing to provide reports to the Department as required in this chapter; or

3. Knowingly and willfully failing to pay in a timely manner the contribution to the Fund by a hospital as calculated by the Department pursuant to § 32.1-337.

B. Conviction of any provider or any employee or officer of such provider of any offense under this section shall also result in forfeiture of any payments due.

History
(1989, cc. 635, 747; 1990, cc. 859, 873.)

Annotations

Cross references. - As to punishment for Class 1 misdemeanors, see 18.2-11.

§ 32.1-342. Rights and responsibilities under this chapter.

Statute text

This chapter shall not be construed as (i) creating any legally enforceable right or entitlement to payment for medical services on the part of any medically indigent person or any right or entitlement to participation or payment of any particular rate by any hospital or other participant or (ii) relieving any hospital of its obligations under the Hill-Burton Act or any other similar federal or state law or agreement to provide unreimbursed care to indigent persons.

History
(1989, cc. 635, 747.)